From: Rynn, Andrea J. [redacted]
Sent: Friday, November 29, 2013 12:02 PM
To: Veltri, Victoria; SIM, OHA
Cc: Rynn, Andrea J.
Subject: SIM Comments

Good morning,

We appreciate the opportunity to comment on the draft SIM plan. The plan was well written and obviously represented a great deal of work and we thank you for that effort. Generally, there were many good ideas represented and in order to realize the triple aim, we respectfully offer the following suggestions and questions:

* We applaud the consumer engagement strategies understanding that the success of major reform will require a level of patient engagement and responsibility beyond what we see today.
* We suggest the work ahead will benefit from broader collaboration to include more hospital and physician representation especially practicing primary care and emergency physicians who bring the perspective of the safety net to the discussion. Prevention and primary care residency programs with strong programmatic outcomes should also be included.
* Specifically, diversify the recommendations and input on the Workforce Taskforce to include those entities, like WCHN, currently operating successful Prevention and Primary Care Residency Programs. Ours is in partnership with the local FQHC and implements the new model of medical home.
*

The federal government has already invested significantly in innovative primary care workforce training in CT by funding primary care training programs of UCONN, Danbury, and CIFC(FQHC).
We expect that State will focus on further funding and expanding of these successful models. This will make a strong case for funding CT because future workforce development funding needs to support the current federal investments. There should also be a strong focus on community based primary care training and FQHCs who are designated as Teaching Health Centers, since community based programs have been far more successful than their counterparts in the academic medical centers. Ours is a federally recognized model that could be expanded statewide.

* Currently a majority of Medicaid beneficiaries are seen by the FQHC's which have a completely different payment mechanism than traditional care delivery settings. The health centers receive wrap around payments (which are higher) per visit instead of traditional fee for service payments. How will the state reconcile and aggregate the experience that the Medicaid beneficiary receives at the FQHC with care received in a traditional setting, if indeed the goal is to create an all claims payer database for population health?
* The FQHC's quality and cost metrics are overseen by HRSA. The metrics are calculated by facility, not physician within that facility. Did the grant committee review the HRSA metrics before creating new state wide requirements? And how would they apply bonuses to individual physicians if metrics are aggregated at the clinic level?
* It is our understanding is that FQHC's can't receive additional payments for Medicaid beneficiaries or it could impact their wrap around payments...has this been investigated?
* Regarding IT/EMR, we didn't see mention of the investments that hospitals and physicians have made into meaningful use for the development of patient portals or for investments in EMR's. WCHN's had the first EMR in CT and is currently upgrading systems and sharing access throughout the public health and provider community. Does the granting committee propose to duplicate efforts (and costs) by asking the federal government for dollars to fund both initiatives? In addition, should we consider this might alienate those providers who have already gone down this path without financial assistance from the state?
* How will the granting committee justify going to the federal government for additional dollars to fund a statewide HIE when the last effort proved so difficult? Or is it the Committee's intent that this funding would go directly to hospitals/providers to offset their millions spent on HIE investments?

* Regarding data collection and reporting, which all comes at a cost, please consider the many individual reporting requirements in place today for hospitals and providers to create new efficiencies rather than redundancies. For instance, could some required reporting be sun-set for a new more efficient data sharing model via collation and sharing state agency to state agency?
* Recognition of the changing hospital landscape in CT and the interest and effect of for-profit entities in our state. In seeking opportunities for greater access and improved care Western CT Health Network (a not-for-profit provider) recently merged with New Milford Hospital and is awaiting approval from DPH/OHCA to affiliate with Norwalk Hospital. This should strengthen our financial base and provide cost savings through economies of scale.
* Finally, we urge that timing considerations and appropriate funding/payments will support successful implementation.

We offer our physicians and staff to participate in any future committees or discussions on this matter. Thank you for this opportunity to comment.

Sincerely,

Andrea Rynn

Director of Public and Government Relations

Western CT Health Network